IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 9016

August 9, 2006

Renae Oswald, Administrator
Eastern Idaho Regional Medical Center Transitional Care Unit
3100 Channing Way, P.O. Box 2077
Idaho Falls, ID 83403

Provider #: 135115

Dear Ms. Oswald:

On July 26, 2006, a fire safety survey was conducted at Eastern Idaho Regional Medical Center - Transitional Care Unit by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be a pattern of deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 22, 2006**. Failure to submit an acceptable PoC by **August 22, 2006**, may result in the imposition of civil monetary penalties by **September 11, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 30, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 30, 2006**. A change in the seriousness of the deficiencies on **August 30, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 30, 2006** includes the following:

Denial of payment for new admissions effective **October 26, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 26, 2007**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 26, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 22, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 22, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction

MPG/dmj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135115	A. BUILDING 01 - ENTIRE NF FLOOR B. WING _____	07/26/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REG MED CTR TCU	PO BOX 2077 IDAHO FALLS, ID 83403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS A Fire / Life Safety Survey was conducted At Eastern Idaho Regional Medical Center TCU on 7/26/2006. The 2000 Existing Edition of the Life Safety Code was utilized for this survey. This facility is type 1 construction and has multiple stories. The TCU is located on the sixth floor. Fire protection features include a complete automatic fire extinguishing system throughout; and a fire alarm/smoke detection system. Currently the facility is licensed for 16 beds. On the day of the survey they had a census of 11 residents. The deficiencies identified during this survey are listed below: The surveyors conducting the survey were: Debby Ransom, RN, RHIT, Bureau Chief Facility Standards Mark Grimes, Supervisor Facility Fire / Life Safety Program Taylor Barkley Health Facility Surveyor	K 000		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress	K 027	Citation K027: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents that were present at survey have been discharged. On July 27th maintenance engineers repaired the latches on the doors to positive latch when closed. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? Since this issue is resolved, no other residents have the potential to be affected. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? A preventative maintenance program will be put into place to prevent this from reoccurring. At the August staff meetings, education will be done to nursing staff related to entering a work order if they observe the doors not latching when closed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Bi-annually preventative maintenance will be performed on all fire rated doors by maintenance engineers overseen by Grant Gohr. 5. Include dates when corrective action will be completed. Aug 30, 2006	08/30/06

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AUG 22 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	NHA	082106

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these

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	135115	A. BUILDING 01 - ENTIRE NF FLOOR B. WING	07/26/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REG MED CTR TCU	PO BOX 2077 IDAHO FALLS, ID 83403

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K 027	Continued From Page 1 and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This Standard is not met as evidenced by: Based on observation, the facility failed to assure that all doors in smoke barriers were self-closing and sealed against the passage of smoke. This deficient practice affected five of eleven residents. Findings include: During the facility tour on 07/26/06 it was observed by the survey team and maintenance staff that the smoke doors by room 608 did not close and latch completely when released.	K 027	Citation K 029: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents that were present at survey have been discharged. On July 27th maintenance engineers replaced the ceiling tiles and corrected this deficiency. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? Since this issue is resolved, no other residents have the potential to be affected 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? At the August staff meetings, education will be done with nursing staff, instructing them to enter a work order if they see missing or stained ceiling tiles. Ancillary services that access the plenum space will be re-educated related to the requirement of ceiling tiles being replaced. This will include information technologies, contractors, and current maintenance staff. Orientation of new maintenance engineers will include education related to ceiling tiles. Information technology staff will be educated at their staff meeting on August 22, 2006. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	08/30/06
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based upon surveyor observation and staff interview, it was determined the facility did not maintain the required separation of a hazardous area. This deficiency affected staff and five of eight residents in	K 029		

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K 029	Continued From Page 2 the wing. Findings included: On 7/26/06 an observation of the soiled linen room revealed two missing ceiling tiles. Maintenance staff stated there had recently been work done in the plenum space and they forgot to replace the tiles.	K 029	Preventative maintenance done related to fire/smoke penetration will now include observation for condition and presence of ceiling tiles. Observing presence and condition of ceiling tiles will be included in safety rounds conducted by safety committee bi-annually. 5. Include dates when corrective action will be completed. August 30, 2006.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Based upon surveyor observation and staff interviews made on 07/26/06, it was determined that the facility did not ensure that exit access corridors are maintained free of obstructions for the full required width of the corridor. Two of two exit corridors were affected. Findings included: Two of two exit access corridors in the facility were observed by survey team and maintenance staff to have chairs, medical carts and linen carts stored against the corridor walls. Staff interviews confirmed the storage of these items in corridors.	K 072	Citation K 072: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents that were present at survey have been discharged. Excess items were relocated to a vacant room. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents admitted to TCU have the potential to be affected by this practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? At the August staff meetings, education will be conducted to all TCU staff related to policy of having no storage of items in the exit access corridors. Linen carts will be removed from the hallways. Linen bags will be provided to each room so that linens can be placed in the bag and the bag can then be removed to the soiled linen room. Medical carts will be stored in a storage area and brought out only when in use.	08/30/06

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K 147	Continued From Page 3	K 147	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Environmental survey of exit access corridors will be conducted by assigned personnel daily for one month. Environmental rounds of exit corridors will be weekly thereafter. 5. Include dates when corrective action will be completed. August 30, 2006	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on surveyor observation it was determined that the facility failed to ensure compliance with electrical safety regulations. The facility had a census of 11 on the day of the survey. All residents and staff were affected. Findings included: Observation in the nurses station on 7/26/06 revealed a powerstrip supplying power to five appliances and another powerstrip. The findings were observed by survey team and maintenance staff.	K 147	Citation K 147: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents that were present at survey have been discharged. On August 1st an electrician added another power drop and corrected this deficiency. One power strip was removed and plugs were relocated to the new outlets. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? No further residents have the potential to be affected by this practice as the deficiency has been corrected. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Education will be done to all clinical staff at August staff meetings that this practice is not acceptable. Ancillary staff, including IT personnel will be	08/30/06

Bureau of Facility Standards

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. A Fire / Life Safety Survey was conducted At Eastern Idaho Regional Medical Center TCU on 7/26/2006. The 1985 Existing Edition of the Life Safety Code was utilized for this survey. This facility is type 1 construction and has multiple stories. The TCU is located on the sixth floor. Fire protection features include a complete automatic fire extinguishing system throughout; and a fire alarm/smoke detection system. Currently the facility is licensed for 16 beds. On the day of the survey they had a census of 11 residents. The deficiencies identified during this survey are listed below: The surveyors conducting the survey were: Debby Ransom, RN, RHIT, Bureau Chief Facility Standards Mark Grimes, Supervisor Facility Fire / Life Safety Program Taylor Barkley Health Facility Surveyor	C 000	educated as well. Information technology staff will be educated at their staff meeting on August 22, 2006. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The safety rounds checklist has been amended to include, "only one power strip can be used for each outlet". Safety rounds are done bi-annually, and are overseen by NHA and the safety committee. 5. Include dates when corrective action will be completed. August 30, 2006 C 230: Refer to K027, K029, K072 and K147 RECEIVED AUG 2 2 2006 FACILITY STANDARDS	08/30/06
C 230	02.106,02,b b. Existing facilities licensed prior to the effective date of these rules, regulations and minimum standards and in compliance with a	C 230		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: DHA | (X6) DATE: 08/21/06

Bureau of Facility Standards

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C 230	Continued From Page 1 previous edition of the Life Safety Code may continue to comply with the edition in force at that time. This Rule is not met as evidenced by: Refer to K027, K029, K072, K147 on the CMS - 2567.	C 230		